STATE OF VERMONT

HUMAN SERVICES BOARD

In re	)	Fair Hearing No. 20,389
	)	
Appeal of	)	

INTRODUCTION

The petitioner appeals the decision by the Department of Disabilities, Aging and Independent Living (DAIL), Division of Licensing and Protection substantiating a report of abuse against the petitioner involving an elderly resident of a nursing home where the petitioner was employed. The issues are whether the Department's decision is supported by the evidence and consistent with its discretion under the pertinent statutes.

FINDINGS OF FACT

1. On December 29, 2005, the Department received a report from a nursing home that an aide employed by the facility had been accused of abusing one of the residents at the facility. Upon its investigation the Department learned that two of the petitioner's coworkers had alleged that they had observed the petitioner push an elderly resident into a bathroom hallway causing her to fall. The Department's investigation culminated with a Commissioner's Review Hearing held on May 5, 2006, after which the Department determined

that the report of abuse was "substantiated". This appeal followed.

2. At the hearing, held on August 18, 2006, one of the coworkers in question, a licensed nurse assistant, testified that on December 29, 2005 she and the petitioner were preparing to assist in "toileting" an elderly female resident who had severe dementia. The resident was ambulatory but was often argumentative and resistant to toileting.

3. The coworker testified that while the petitioner was attempting to usher the resident into a small hallway leading to the bathroom the resident was being resistant, and she observed the petitioner forcibly push the resident from behind causing the resident to fall to the floor. Fortunately, the resident was not injured, but while other staff were examining her for injuries the resident was yelling to them and gesturing to the petitioner, "get her away from me".

4. The coworker testified that she was standing in the bathroom when the incident occurred and that she clearly saw the petitioner place her hands on the resident's back and give the resident a "forward push" into the bathroom hallway, which caused the resident to fall.

5. The coworker also testified that she considered the petitioner a friend and that she was greatly upset by what she had observed. She stated that she was "torn" about

reporting it, and did so only after she had conferred with other staff. The coworker testified at the hearing under subpoena by the Department.

6. The coworker admitted that two weeks after the incident (in the midst of the Department's investigation), in an email exchange with the petitioner, she had told the petitioner that she had told "everyone" that she did not know how the resident had gotten on the floor that day. In fact, however, the coworker had told her employer and the Department's investigator the same version of the event that she testified to at the hearing (*supra*).

7. Based on the coworker's demeanor at the hearing, her testimony regarding the incident is deemed highly credible. Her recollection was detailed, and it is consistent with what she reported to her supervisors and to the Department's investigator. Although she later told *the petitioner* that she had not actually seen the resident fall, her testimony that this was an attempt to keep the petitioner's friendship is consistent with the overall tone and content of the email in question, and it strikes the hearing officer as understandable and credible.

8. Another of the petitioner's former coworkers, an "activities assistant", also testified at the hearing. This witness stated that at the time in question she was seated at the nurses' station several feet up the main hall from the

bathroom. She stated that she observed the resident being resistant to the petitioner's attempts to lead her down the main hall, past the nurses' station, toward the bathroom. She testified that when the petitioner and the resident reached the bathroom hallway (which ran perpendicular to the main hallway) the petitioner ordered the resident to turn toward the bathroom, and that she put her hands on the resident's back and pushed her into the bathroom hallway, at which point the resident fell to the floor.

9. The second coworker's testimony was also deemed credible. Both eyewitnesses described the resident's fall to the floor as sudden and instantaneous, and they stated that when the petitioner was on the floor her upper torso was in the bathroom hallway and her legs were protruding into the main hall.

10. A third coworker, an LPN who at the time in question was standing in the nurses' station but admittedly out of visual line from the bathroom hallway, also testified at the hearing. She stated that she quickly arrived on the scene after hearing a "commotion" from down the hall, and that she examined the resident while she was still on the floor and determined that she was not injured. This witness verified that the resident was visibly and verbally angry with the petitioner.

11. This witness also corroborated that the first witness (see *supra*) was upset and initially reluctant to report what she had observed. The LPN testified that she carefully elicited the detail from the first witness that she had actually seen the petitioner forcibly push the resident into the bathroom hallway.

12. At all times, including the hearing, the petitioner has adamantly denied that she pushed the resident. She maintains that she merely had placed her hands on the resident's back and that the resident had suddenly and violently swung her arms around at her, which pushed her (the petitioner) into the wall and caused her to lose her balance. The petitioner testified that when she bounced off the wall she crashed into the resident and that she reached out to grab the resident to break the resident's fall. The petitioner stated that she was unable to prevent the petitioner's fall, but that she was able to "ease" her down slowly by "holding" her with her hands.

13. The petitioner's version of the event is plausible[1], but it cannot be credibly reconciled with the observations of the other witnesses (*supra*) that there was a definite "push" by the petitioner and that the resident's fall was sudden. There is no credible evidence that any of the witnesses who

[1] The other witnesses verified that the petitioner initially claimed that the resident had pushed her, and that this had hurt her arm.

testified at the hearing for the Department had any bias against the petitioner or any reason to fabricate or exaggerate the allegations against her. The investigations on the part of the nursing home and the Department appear to have been thorough and open-minded.

14. Based on the testimony presented by the Department at the hearing it is found that the petitioner intentionally pushed the resident in a direction against the resident's will with sufficient force to knock the resident off her feet.

15. It appears that the incident in question was isolated, and that the petitioner otherwise was a caring, experienced and competent employee.

ORDER

The Department's decision is affirmed.

REASONS

The Commissioner of DAIL is required by statute to investigate reports regarding the abuse of elderly persons and to keep those reports that are substantiated in a registry under the name of the person who committed the abuse. 33 V.S.A. § 6906, 6911(b). Persons who are found to have committed abuse may apply to the Department for a review of that decision. 33 V.S.A. § 6906(c). Lack of relief after

this review is appealable to the Human Services Board pursuant to 3 V.S.A. § 3091. 33 V.S.A. § 6906(d).

The statute which protects elderly adults, 33 V.S.A. § 6902, defines "abuse" to include the following:

> (1) "Abuse" means:
>
> (A) Any treatment of an elderly or disabled adult which places life, health or welfare in jeopardy or which is likely to result in impairment of health; [or]
>
> (B) Any conduct committed with an intent or reckless disregard that such conduct is likely to cause unnecessary harm, unnecessary pain or unnecessary suffering to an elderly or disabled adult. . .

As found above, the petitioner's conduct in this case, though apparently isolated and atypical, and not causing any actual injury to the resident in question, was intentional rather than accidental. It must be concluded that pushing an elderly nursing home resident in a direction against her will with sufficient force to knock her off her feet constitutes "an intent or reckless disregard that such conduct is likely to cause unnecessary harm, unnecessary pain or unnecessary suffering" within the meaning of subsection (B) of the above statute.[2] Nothing in the statute requires a finding of more than one incident, and nothing allows mitigation in cases, such as it appears here, where the act was isolated or uncharacteristic on the part of the alleged perpetrator.

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[2] In noting the intent of the elderly abuse statutes (see 33 V.S.A. § 6901) the Board has repeatedly observed that "residents in nursing homes have an expectation of trust and security from their caregivers which must be maintained as an integral part of their welfare". Fair Hearings

Thus, it must be concluded that the petitioner's action in this case constituted "abuse" of an elderly person within the meaning of the statute.

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No. 15,190; 12,580 and 12,187.